"ELECT TO PARTICIPATE"
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA) APPLICATION

PURPOSE: To confirm that an Indian Health Services (IHS) facility clinic **elects** to participate under the Indian Health Services Memorandum of Agreement (IHS/MOA) program. Detailed instructions on page 2 of the application.

GENERAL INSTRUCTIONS: Please complete **one application for each** clinic, including all satellite clinics. **Please refer to instructions on page 2 of this application.**

IHS parent clinic name			Medi-Cal provider number
Parent service location address	City	State	ZIP code
Satellite clinic name			
Satellite clinic address	City	State	ZIP code

INSTRUCTIONS: Please check one of the following. Also check if the clinic is on or off tribal land.

☐ I have been participating as a PCC, FQHC, or RHC under Medi-Cal and elect to enroll under the IHS/MOA program.

☐ On tribal land ☐ Off tribal land

List intermittent clinic name(s) and address(es) that operate less than 20 treatment hours per week.

INTERMITTENT CLINIC NAME	ADDRESS

☐ I am **NOT** a Medi-Cal provider clinic but **elect** to participate in the IHS/MOA program.

Signature	Date	Telephone number
Print name	Title	

Please return this application to:

Attention: IHS/MOA 638 Application
DHS Medi-Cal Benefits Prof. Serv. Unit
714 P Street, Room 1640
P.O. Box 942732
Sacramento, CA 94234-7320

Faxed applications will not be accepted.

INSTRUCTIONS

IHS PARENT CLINIC NAME: Enter the parent clinic name that wishes to enroll in the IHS/MOA program. The parent clinic must complete a separate form for each satellite clinic. If you do not have satellite clinics, enter the name of your clinic.

MEDI-CAL PROVIDER NUMBER: Enter the complete nine-digit Medi-Cal provider number.

PARENT SERVICE LOCATION ADDRESS: Enter the street address, city, and ZIP code of the clinic. Do not enter a P.O. Box address. The address must represent the physical location where services are rendered.

SATELLITE CLINIC NAME: Enter the name of the satellite clinic. Complete one application for each satellite clinic. Satellite clinics must operate more than 20 treatment hours per week. If you do not have satellite clinics, leave blank.

SATELLITE CLINIC ADDRESS: Enter the street address, city, and ZIP code of the clinic. Do not enter P.O. Box address. The address must represent the physical location where services are rendered.

PCC OR FQHC/RHC PROVIDER: Check if the clinic participates as a PCC, FQHC, or RHC under the Medi-Cal program.

ON TRIBAL LAND: Check if the parent clinic is located on federally recognized tribal land as stated under California's Health and Safety Code, Section 1206.

OFF TRIBAL LAND: Check if the parent clinic is off federally recognized tribal land.

INTERMITTENT CLINICS: Enter the names and addresses of all the intermittent clinics under the parent clinic. Attach an additional piece of paper, if necessary.

NOT MEDI-CAL PROVIDER: Check if the clinic is not a Medi-Cal provider clinic but wishes to participate in the IHS/MOA program.

SIGNATURE: Enter the signature of the owner or corporate officer of the clinic.

DATE: Enter the date the application was signed.

TELEPHONE NUMBER: Enter a telephone number of the owner or corporate officer.

PRINT NAME: Print the name of the owner or corporate officer signing the application.

TITLE: Enter the title of the owner or corporate officer signing the application.